Abt Associates Inc.

Evaluation of the Private Fee-for-Service (PFFS) Plans in the Medicare Plus Choice Program

Final Report

Cambridge, MA
Lexington, MA
Hadley, MA
Bethesda, MD
Chicago, IL

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Prepared for
Nancy Zhang, Ph.D.
Centers for Medicare and
Medicaid Services OSP/DHSR
3-22-16 Central Building
7500 Security Boulevard
Baltimore, MD 21244-1850

Prepared by
David Kidder
Andrea Hassol
Louisa Buatti
Andrea Brand
Steven Pizer
Bryan Dowd
Robert Coulam
Elizabeth Axelrod
Louise Hadden
Ryan Kling
Ken Lam
Nusrat Shariff

Abt Associates Inc.
55 Wheeler Street
Cambridge, MA 02138

Internal Review

Project Director

Technical Reviewer

Management Reviewer

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Private Fee-for-Service

The Medicare + Choice (M+C) sections of the 1997 Balanced Budget Act (BBA) include a Private Fee-for- Service (PFFS) option for Medicare beneficiaries. Congress intended PFFS to be privately managed insurance for beneficiaries who wanted fee-for-service (FFS) coverage. PFFS entered the market during a time of turbulence in the M+C program. Following payment changes in the BBA, many plans exited the Medicare program or sharply curtailed benefits. During this period of M+C contraction, PFFS was embodied in two plans: Sterling Life Insurance's "Option I[SM]" and Humana Inc.'s "Gold Choice[SM]." Within the past year, in response to a more generous payment methodology incorporated in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), M+C plan participation increased and enrollment began to recover.

In September 2001, CMS awarded Abt Associates Inc. a contract to evaluate PFFS, focusing on Option I[SM] and, somewhat less intensively, on Gold Choice[SM]. This is the final report of the PFFS evaluation.

Scope and Focus of the Evaluation Final Report

This final report combines and synthesizes findings from several earlier analyses to address the major research questions of the evaluation:

- How did plans design and implement PFFS?
- Who enrolled in PFFS (and disenrolled from PFFS), and why did they enroll/disenroll?
- What has been the impact of the program so far on:
  - Persons who enrolled in PFFS?
  - The health care system?
  - The Medicare program?

Data Sources

This evaluation acquired qualitative and quantitative data from several sources.

PFFS Plan Case Studies were based on interviews at Sterling and Humana headquarters, as well as data from corporate websites, PFFS plan marketing materials and government documents.

Market Area Studies included targeted interviews with stakeholders in Metropolitan Statistical Areas (MSAs) where Sterling marketed Option I[SM]. In 2004, evaluators conducted similar interviews in Humana's Gold Choice[SM] service area and four focus groups of Humana Gold Choice[SM] enrollees.

Market Entry and Enrollment Analyses used Medicare Enrollment Database (EDB) and market area data to study Option I[SM] patterns of market entry, compare Option I[SM] enrollees and disenrollees to non-enrollees in Sterling's Option I[SM] service area, and compare Humana Gold Choice[SM] enrollees and disenrollees to non-enrollees in Humana's Gold Choice[SM] service area.

National Enrollee Survey was a mail survey with phone follow-up of a sample of Option I[SM] enrollees and a comparison sample of other Medicare beneficiaries living in Option I[SM] service area counties.

National Disenrollee Survey: the Research Triangle Institute (RTI) added PFFS disenrollees to the sample for the 2002 Medicare Satisfaction Survey - DR (Disenrollment Reasons), a survey module of CAHPS ® (Consumer Assessment of Health Plans).

Summary of Major Findings

Sterling Option I[SM]

Option I[SM] experienced cycles of growth and contraction during its first four years. Rapid Option I[SM] growth over the first two years seems to have been due at least in part to the exits of other M+C plans in the service area. Contraction reflected a combination of a high voluntary disenrollment rate (as much as three times the rate of disenrollment from other M+C plans) and a Sterling's decision to exit from over 500 counties between 2003 and 2004.

Throughout the study period, Option I[SM] enrollment remained concentrated in a few states and counties; market penetration was low throughout the Option I[SM] service area. Initially, Option I[SM] enrollment was concentrated in Texas and Louisiana. By 2004, enrollment was distributed somewhat more evenly among states in the service area, but overall penetration never exceeded one percent of eligible beneficiaries in any state during the study period.

Stakeholders were initially confused about PFFS. However, providers seem to have accepted the program. Eligible beneficiaries, both enrolled and non-enrolled in Option I[SM], were confused about Option I[SM]. As late as 2004, some local stakeholders were unfamiliar with the program. Yet early evidence of resistance among some providers seems to have disappeared in market areas studied for the evaluation.

Compared to other M+C plan, Sterling enrolled a relatively young and rural enrollee population. Most early enrollees came from other M+C plans. Compared to the average beneficiary in Original Medicare or other M+C plans in the Option I[SM] service area, Option I[SM] enrollees tended to be white, young (among aged enrollees), more likely to be disabled, previously in another M+C plan, and living in rural counties. Over the study period, even though the enrollee population aged, the share of disabled enrollees increased. The proportion of Option I[SM] enrollees previously in Original Medicare increased as well.

Freedom of choice attracted enrollees to Option I[SM]. Option I[SM] respondents to the National Enrollee Survey were more likely than others to mention freedom to choose providers as a reason for enrollment. They were also more likely to note that Option I[SM] was the only insurance available to them.

There was no evidence of widespread access problems in Option I[SM]. Option I[SM] enrollees were more likely than others to report access problems for home health and durable medical equipment, both of which had high rates of co-insurance. [1] However, there were no differences between Option I[SM] enrollees and other Medicare beneficiaries in reported access to hospital, physician and other services. In all plan arrangements, disabled beneficiaries were more likely than aged beneficiaries to report access problems. Disenrollees from Option I[SM] were less likely than other M+C disenrollees to cite access problems as reasons for leaving.

Option I[SM] enrollees expressed somewhat greater satisfaction with their plan than other M+C and Original Medicare beneficiaries. Both M+C and Original Medicare beneficiaries seemed somewhat less satisfied overall and with complaint procedures than Option I[SM] enrollees. Option I[SM] disenrollees

[1] In the 2004 version of Option I[SM], Sterling reduced rates of co-insurance for home health (from 35 percent to 25 percent) and DME (from 50 percent to 40 percent).

were less satisfied than current Option I[SM] enrollees. Disabled Option I[SM] enrollees lodged complaints more often than their aged counterparts, but were typically more satisfied with how their complaints were handled and with their insurance overall.

There was inconsistent evidence on selection bias, based on self-reports. In general, there was no evidence that Option I[SM] enrollees or disenrollees were more or less healthy or functionally challenged than Medicare beneficiaries in Original Medicare and other M+C plans. Although disabled Option I[SM] enrollees were more likely to report functional impairments, they reported fewer chronic conditions and viewed their health current and future health status more positively than other disabled beneficiaries.

Humana Gold Choice[SM]

Enrollment growth has been steady and rapid. In its brief history, Gold Choice[SM] has grown steadily, from zero in February 2003 to 11,590 by September 2004.

Gold Choice[SM] enrollment has been geographically concentrated and market penetration has been low throughout the service area. During the study period, over three-quarters of Gold Choice[SM] enrollees lived in Wisconsin and Iowa. Across the Gold Choice[SM] service area, market penetration remained well below one percent.

Beneficiaries, providers and other stakeholders demonstrated a lack of knowledge of Gold Choice[SM]. Even in Wisconsin and Iowa, markets with the highest Gold Choice[SM] penetration, half of the stakeholders contacted for this evaluation had no knowledge of the program.

Gold Choice[SM] enrolled a relatively young and rural enrollee population. Most early enrollees came from Original Medicare. Compared to the average beneficiary in Original Medicare or other M+C plans in the Gold Choice[SM] service area, Gold Choice[SM] enrollees tended to be white, young, more likely to be disabled, previously in Original Medicare, and living in rural counties.

Gold Choice[SM] experienced a relatively modest rate of disenrollment. Over the first year and a half, the Gold Choice[SM] disenrollment rate was no different from the average for other M+C plans. Compared to current enrollees, disenrollees tended to be older, more likely to be disabled, and more likely to live in rural counties or in counties adjacent to urban areas than current enrollees.

A low-cost premium attracted enrollees to Gold Choice[SM]. Cost was by far the most important reason why focus group participants purchased Gold Choice[SM].

There was no evidence of access or satisfaction problems. Few focus group participants had experienced any difficulty getting their doctors to accept Gold Choice[SM]. Most planned to continue in the program, and many had recommended Gold Choice[SM] to others.

Conclusion: PFFS After the Medicare Modernization Act

Seven years after passage of the Balanced Budget Act of 1997, and four years after Sterling Life Insurance introduced Option I[SM], PFFS' accomplishments have been modest. PFFS remains a small program, unavailable in many parts of the country, with limited market presence in those areas where it is available.

Recently, several factors suggest that PFFS' prospects may have improved. Humana Gold Choice[SM] enrollment has grown steadily since 2003, and Humana began marketing Gold Choice[SM] in an expanded geographic service area in August 2004. Sterling Option I[SM] has apparently reversed a downward trend in enrollment and shows some signs of growth. In the last year, two new PFFS

products have entered the market. Additionally, PFFS plans share the benefits conferred on Medicare Advantage plans by the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) in the form of higher payment rates. Perhaps partly in response to these more favorable rates, there has been a modest increase in the number of PFFS applications pending.

The future success of PFFS depends on several factors, including strategic and tactical decisions by current PFFS plans and new entrants, as well as external market and regulatory forces over which plans have little control.

Sterling entered the PFFS market with a single product sold at a uniform premium throughout its service area. Over time, Sterling made modifications to Option I[SM] by raising premiums, by withdrawing from part of its initial service area and by diversifying the product. This strategy may pay off, as recent increases in Option I[SM] enrollment seem to suggest.

It is too soon to tell how new PFFS entrants will adjust to evolving market conditions. Sterling's experience with M+C before it offered Option I[SM] was limited. Other plans, (like Humana which brought its extensive M+C experience to the process of designing and marketing Gold Choice[SM]) may apply very different benefit designs and marketing approaches for their PFFS products.

1.0 Introduction

1.1 Private Fee-for-Service

The Medicare + Choice (M+C) sections of the 1997 Balanced Budget Act (BBA) include a Private Fee-for- Service (PFFS) option for Medicare beneficiaries. As part of a policy to increase competition and choice, Congress intended PFFS to offer a privately managed option for beneficiaries who wanted fee-for-service (FFS) coverage. It was thought that PFFS plans, paid county-specific M+C capitation rates for PFFS enrollees, could compete on price, and perhaps on benefit coverage, for beneficiaries who faced escalating costs of conventional Medicare supplemental (Medigap) coverage.

PFFS entered the market during a time of turbulence in the M+C program. Enrollment in M+C plans had peaked at 6.3 million in 1999. Following payment changes in the BBA, many plans exited the Medicare program or sharply curtailed benefits. The numbers of M+C Coordinated Care Plans (CCPs) dropped from 346 in 1998 to 156 in 2002 (Gold, April 2003). M+C enrollment dropped to 4.6 million in 2003.

During this period of M+C contraction, PFFS was embodied in two plans. In May 2000, Sterling Life Insurance of Glenview, Illinois (Sterling) received approval from the Centers for Medicare and Medicaid Services (CMS), to implement PFFS. In June 2000, Sterling began offering "Option I^{SM}" in 17 states and 1,222 counties. In January 2001, Option I^{SM} was offered in 1,670 counties in 25 states. Nearly three years after Sterling first offered Option I^{SM}, only Humana Insurance Co., a subsidiary of Humana Inc., had received CMS approval to market PFFS products in Iowa, Minnesota, Wisconsin and parts of North and South Dakota. Humana began to enroll beneficiaries in its PFFS product, "Humana Gold Choice^{SM}," in January 2003.[2]

Within the past year, in response to a more generous payment methodology incorporated in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), M+C plan participation in Medicare increased and enrollment began to recover. In addition, three new plans have begun marketing PFFS products: UNICARE Life and Health Insurance Company, United Healthcare Insurance Company, and American Progressive Life and Health Insurance Company. In July 2004, CMS reported a pending PFFS application from another plan. Total PFFS enrollment, which was just over 25,000 in 2003, had increased to over 35,000 by July 2004.[3]

In September 2001, CMS awarded Abt Associates Inc. a contract to evaluate the PFFS option, focusing on Option I^{SM}. Shortly after Humana began marketing Gold Choice^{SM}, CMS asked Abt Associates to include Humana Gold Choice^{SM} in the evaluation.

This is the final report of the PFFS evaluation.

1.2 Scope and Focus of the Evaluation Final Report

Throughout this evaluation, findings were reported as analyses were completed. Most of these reports were organized around analyses of specific data sources. This final report combines and synthesizes findings to address the major research questions of the evaluation:

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[2] Since January 2002, Humana has offered PFFS in DuPage County, Illinois on a demonstration basis.

[3] CMS Medicare Managed Care Monthly Summary Report. December 2003, July 2004.

- How did plans design and implement PFFS?
- Who has enrolled in PFFS (and disenrolled from PFFS), and why did they enroll/disenroll?
- What has been the impact of the program on:
  - Persons who enrolled in PFFS?
  - The health care system?
  - The Medicare program?

Key primary data for the evaluation came from surveys, targeted interviews and focus groups. Comparable baseline (pre-PFFS) data were not available. Therefore, the core design for measuring impacts was based on concurrent comparisons of PFFS enrollees to other Medicare beneficiaries.

Over the years covered by the evaluation, PFFS had not yet become a national "program" offered by many plans throughout the US. Therefore, it is impossible to generalize about PFFS history and impacts apart from the specific experiences of the two companies that first offered PFFS. Because Sterling marketed the first PFFS product, the most comprehensive findings from the evaluation pertain to Option I[SM]. Some, but not all, of the data collection and analyses were replicated for Humana's Gold Choice[SM]. As succeeding sections of this report will demonstrate, though each product was consistent with broad legislative guidelines for PFFS, from the beginning, Option I[SM] and Gold Choice[SM] were different in benefit structure, premium rates, and cost sharing levels. Sterling and Humana approached process development and marketing of their PFFS products differently as well. For these reasons, this report addresses each research question separately for Sterling Option I[SM] and Humana Gold Choice[SM].

1.3 Contents of the Report

Chapter 2 describes primary and secondary data and the analysis methods used to address the evaluation questions. Chapter 3 presents findings, organized around the major research questions. Chapter 4 summarizes the evaluation's principal findings, and offers a brief discussion of PFFS after the Medicare Modernization Act.

2.0 Data and Methods

2.1 Data Sources

The evaluators gathered qualitative and quantitative data from several sources. No one source provided data adequate to address any one of the core research questions, as Exhibit 2.1 shows. For example, in order to address enrollment and disenrollment issues, evaluators drew on research literature, used data from the National Enrollee Survey and the National Disenrollee Survey to assess beneficiary knowledge and decision making, and compared PFFS enrollees to other Medicare beneficiaries, using Medicare EDB and market area data.

Exhibit 2.1 shows that, because of differences in data availability between the two PFFS plans, it was possible to conduct a wider range of analyses of Option I[SM] (particularly of program impacts) than of Gold Choice[SM]. There are two reasons for these differences. First, Humana began marketing Gold Choice[SM] in 2003, leaving little time in the evaluation to observe impacts. Second, Humana's late entry occurred after both the National Enrollee Survey and the National Disenrollee Survey were in

the field. Both of these surveys, described below, provided important quantitative evidence on selection issues and program impact for Sterling Option I[SM]. However, time and resources did not permit similar data collection efforts for Gold Choice[SM]. Focus groups of 40 Gold Choice[SM] enrollees offer an informative but limited picture of perceptions and experiences, but they do not support analyses either of program impact or of selection bias.

The following sections present brief descriptions of major data sources.

Exhibit 2.1: Data Sources and Uses

Data Sources/Uses[4]	Plan Experiences	Enrollment/ Disenrollment	Enrollee Impacts	System Impacts	Medicare Impacts
Case study/site visit (S,H)	X	--	--	--	--
Literature/websites (S,H)	X	X	--	X	--
Market area interviews (S, H)	X	--	X	X	--
Enrollee focus groups (H)	--	--	X	X	--
National Enrollee Survey (S)	--	X	X	--	X
National Disenrollee Survey (S)	--	X	X	--	X
Medicare Enrollment Database (S,H)	--	X	--	--	X

[4] Data sources for Sterling Option I^{SM} (S) and Humana Gold Choice^{SM} (H)

2.1.1 PFFS Plan Case Studies

In 2001, evaluators conducted interviews with key managers during a site visit to Sterling corporate headquarters in Bellingham, Washington (since moved to Glenview, Illinois). In 2003, evaluators visited Humana headquarters in Louisville, Kentucky. Before the site visits, written protocols listing key questions were developed, reviewed by CMS, and forwarded to officials at Sterling and Humana. Humana and Sterling representatives also reviewed the protocols in advance of the visit.

To supplement and inform both site visits, evaluators also accessed information from the CMS, Sterling and Humana websites, as well as corporate and financial profiles from independent sources (e.g., Forbes.com). Additional information on Humana's experience came from CMS documents related to the DuPage County, Illinois demonstration and Gold Choice[SM] implementation in 2003 in its Upper Midwest service area.

2.1.2 Market Area Studies

To assess key stakeholders' knowledge and perceptions of PFFS, evaluators conducted two rounds of targeted interviews, in 2002 and 2004, in Metropolitan Statistical Areas (MSAs) where Sterling marketed Option I[SM]. In 2004, evaluators also conducted one round of interviews in Humana's Gold Choice[SM] service area. In order to increase the chances of finding respondents familiar with the program, a key criterion for selecting markets for these studies was PFFS penetration of the eligible Medicare population.

- The first Sterling Option I[SM] market area study included stakeholder interviews in Baton Rouge, Louisiana (four counties); Austin-San Marcos, Texas (five counties); Scranton-Wilkes-Barre-Hazleton, Pennsylvania (four counties); Seattle-Bellevue-Everett, Washington (three counties); Nashville, Tennessee (eight counties).

- The second Sterling Option I[SM] market area study included interviews in Baton Rouge, Louisiana (nine counties); Austin-Round Rock, Texas (three counties); Luzerne County, Pennsylvania; Spokane, Washington (one county); Toledo, Ohio (four counties).

- The Humana Gold Choice[SM] market area study was conducted in Wisconsin and Iowa. In addition to stakeholder interviews, four focus groups of Gold Choice[SM] enrollees were conducted in Milwaukee, Wisconsin and Des Moines, Iowa.

In each of the sites, evaluators interviewed stakeholders at the state and local levels. These included state hospital associations, state medical associations, and state insurance commissions. Because other parts of the evaluation had shown relatively high rates of PFFS enrollment among disabled Medicare beneficiaries,[5] interviews with advocacy groups for persons with disabilities were added to the second Sterling study and to the Humana study. In each local community, representatives from the local State Health Insurance Assistance Program (SHIP) counseling agencies were interviewed. In addition, representatives of several national organizations were interviewed, to assess their perceptions of PFFS. These included the American Association of Health Plans (AAHP)/ Health Insurance Association of America (HIAA), the American Association of Retired Persons (AARP), the American Hospital Association (AHA), the American Medical Association (AMA), and the Medicare Rights Center. During the second Sterling market area study, evaluators also interviewed an official of Advancing Independence: Modernizing Medicare and Medicaid (AIMM), a national organization representing persons with disabilities.

[5] In this report, Medicare beneficiaries under age 65 who are entitled because they are disabled are referred to as "disabled" beneficiaries.

Four focus groups of 40 Humana Gold Choice[SM] enrollees were conducted in June 2004, two in Des Moines, Iowa and two in Milwaukee, Wisconsin. These focus groups provided information on enrollees' perceptions of and experience with Humana Gold Choice[SM]. Information sought was similar to information on Sterling Option I[SM] enrollees collected in the National Enrollee Survey, described below.

2.1.3 Market Entry and Enrollment Analyses

Evaluators used Medicare Enrollment Database (EDB) and market area data to conduct four studies:

- An analysis of Sterling Option I[SM] patterns of market entry. This analysis used both descriptive and multivariate techniques to compare the characteristics of Option I[SM] counties (in December 2001) to other U.S. counties. The analysis used EDB data, as well as extensive market-level information from a variety of Medicare and other sources.[6]

- Two analyses that compared Sterling Option I[SM] enrollees and disenrollees to non-enrollees in Sterling's Option I[SM] market area. The first report was based on data from beneficiaries enrolled in Option I[SM] on or before October 1. The second updated the enrollment analyses through February 1, 2003.

- An analysis that compared Humana Gold Choice[SM] enrollees and disenrollees to non-enrollees in Humana's Gold Choice[SM] market area, based on data from beneficiaries enrolled in Gold Choice[SM] on or before February 1, 2004.

2.1.4 National Enrollee Survey

In late summer and early fall of 2002, Abt Associates conducted a mail survey with phone follow-up of a sample of Option I[SM] enrollees and a comparison group of other Medicare beneficiaries living in Option I[SM] service area counties. The National Enrollee Survey asked questions about respondents' awareness of Option I[SM] and how they learned about it, the basis for their decision (to enroll or, for comparison group members, not enroll), change in out-of-pocket costs, health status, access to health care services, delayed or absent care due to cost concerns, issues of changing providers when making insurance changes, and satisfaction with their plan and quality of care. Characteristics of respondents identified as "control variables" for purposes of cross tabulations and multivariate analyses included living arrangement, educational attainment, race and ethnicity and availability of other health insurance coverage.

The initial sample was drawn from a frame with seven strata. Three strata defined the Option I[SM] "Ever Enrolled" group: 1) Option I[SM] disenrollees, 2) current Option I[SM] enrollees who had previously been in an M+C plan, and 3) current Option I[SM] enrollees who had been in Original Medicare. The comparison group was sampled from four strata: 1) current Original Medicare enrollees who had been in an M+C plan, 2) current Original Medicare enrollees who had been in Original Medicare, 3) current M+C enrollees who had been in an M+C plan, and 4) current M+C enrollees who had been in Original Medicare.

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[6] These included demographic profiles of enrollees, county/plan M+C enrollment, county Principal Inpatient Diagnosis Cost Group (PIP-DCG) scores, county average Medicare Parts A and B expenditures (CMS); county-level Medigap premiums (Weiss Ratings); hospital beds/person, physicians/person (Area Resource File); U.S. Department of Agriculture urban rural codes; county per capita personal income (U.S. Department of Commerce, Bureau of Economic Analysis).

The sample of 7,730 included 3,543 who were ever enrolled in Option I[SM] and 4,187 who were in the comparison group. Of these, 7,236 were determined to be eligible respondents. A field effort that combined mail with reminders and telephone follow-up yielded a total 5,285 completed and 21 partially completed surveys, for a total of 5,306 responses. Abt mailed advance letters to potential respondents in July 2002, and data collection ended in December 2002. The response rate, including fully and partially completed surveys (5,306 of 7,236), was 73.3 percent. For analysis purposes, each response was weighted to account for the sampling design and non-response.

2.1.5 National Disenrollee Survey

The National Enrollee Sample included a small number of disenrollees (798). Additionally, none of the questions in this survey addressed disenrollees' reasons for their decisions to leave Option I[SM]. To fill this gap, CMS contracted with Research Triangle Institute (RTI) to provide Abt Associates with data from its survey of Medicare + Choice plan disenrollees, including disenrollees from Sterling Option I[SM]. From December 2002 through May 2003, RTI added Option I[SM] disenrollees to the sample for the 2002 Medicare Satisfaction Survey - DR (Disenrollment Reasons), a survey module of CAHPS ® (Consumer Assessment of Health Plans). As requested by CMS, RTI provided Abt Associates with a file that contained respondent-level data from surveys conducted during the last quarter of 2002 and the first quarter of 2003. The instrument addressed reasons for disenrollment, enrollees' experiences with their former plans, experience with and knowledge of the appeals and complaints process, and enrollee characteristics (physical/mental health and function, age, gender, education, race and ethnicity, and assistance in completing the form).

The sampling frame for the 2002 Reasons Survey included all Medicare beneficiaries who voluntarily disenrolled from one of 172 M+C organizations that were in operation for at least a year before the survey year. For the Option I[SM] sample, RTI stratified disenrollees into eight regions with the most disenrollments —Texas, Louisiana, Washington, Oklahoma, Tennessee, Ohio and Pennsylvania. The eighth stratum included the remainder of the Option I[SM] service area. Weights were computed to account for sampling proportions and non-response. The survey file included 25,305 records for sampled Sterling Option I[SM] and other disenrollees. Abt evaluators eliminated a) non-Option I[SM] respondents who did not live in non-Option I[SM] service area and b) respondents who did not leave their plans voluntarily. This reduced the number of respondents to 8,779, of which 1,009 were from Option I[SM] and 7,770 were from other plans. With weights applied, the total "N's" for the final analysis sample were 1,982 for Option I[SM] and 89,105 for other disenrollees.

2.2 Analysis Methods

2.2.1 Qualitative Analysis of PFFS Program Planning/Implantation

The evaluators combined information from targeted interviews, focus groups, surveys and program statistics to create a narrative description of: 1) how Sterling and Humana planned for and implemented PFFS and 2) how various stakeholders, including Medicare beneficiaries, national and state provider and consumer organizations, and state and local SHIPS counselors, perceived and reacted to PFFS. With the exception of the two national surveys, selection of respondents was purposive, not scientific. Therefore, any patterns in the views of respondents from a particular class of stakeholder or in the particular locations chosen for study may be suggestive, particularly when there is corroborating information from other sources. By themselves, however, they cannot be the basis for broader inferences about either of the PFFS plans or PFFS in general.

2.2.2 Descriptive and Multivariate Analysis of Survey and Secondary Data

Evaluators conducted quantitative analyses of data from the two surveys to explore possible selection bias in PFFS and to estimate the impacts of PFFS on access and satisfaction. This report presents statistics that are both adjusted (for various possible confounding factors) and unadjusted. Multivariate models were used for adjustment. Models differed across analyses, depending upon data elements available for creating independent variables. All estimates that were adjusted have been presented with an indication of their statistical significance. Descriptive (unadjusted) statistics are presented without tests of significance.

3.0 Findings

PFFS growth has been constrained by the fact that few plans received CMS approval to market PFFS products during the first four years of the program. Findings from the qualitative and quantitative analyses of this evaluation provide useful information about the first PFFS plans' experiences and impacts. However, they do not represent a full and fair test of the viability of the PFFS model.

By law, all PFFS plans share certain structural and operational characteristics. Among these are:

- Enrollees have free choice of "deemed" providers.[7]
- PFFS plans are not required to contract with networks of providers.[8]
- PFFS plans are responsible for developing fee-for-service provider payment rates and for paying claims.
- Medicare pays PFFS plans the same rates paid all M+C plans.
- Premiums are the same for all enrollees, regardless of where they live in the plan's service area.
- Quality assurance requirements for PFFS are minimal. Plans only have to have written protocols and mechanisms in place for utilization review.
- The actuarial value of all cost-sharing (deductibles, co-payments and coinsurance) for the average PFFS enrollee must not exceed the actuarial value of all cost-sharing required of the average Medicare Part A beneficiary who is also enrolled in Part B.

Beyond these common requirements and characteristics, PFFS plans are free to set premiums, define market areas and structure benefits in ways that they think will achieve their business objectives.

As the program grows, it may be appropriate to create and monitor some aggregate measures that characterize "PFFS." However, two plans, Sterling Option I[SM] and Humana Gold Choice[SM], have thus far effectively defined PFFS in operation. Sterling and Humana launched their PFFS programs from different corporate contexts and offered products that differed in price and, to a lesser degree, in benefit structure. The format for this chapter, divided into sections that present findings separately

[7] Providers are "deemed" for a PFFS plan if they agree to accept the plan's fees and to submit claims to the plan. Providers can be deemed for one of their patients with Option I[SM] coverage but not for another, or for Option I[SM] but not Gold Choice[SM], in areas where both are available.

[8] PFFS plans are not prohibited from contracting with providers, but it is not a requirement for CMS approval.

for Option I[SM] and Gold Choice[SM], highlights this fact. Option I[SM] received more attention throughout this study, because it is the older and larger of the two. Therefore, supported by a more extensive set of primary and second data, findings on Option I[SM] analyses are more comprehensive and grounded in more rigorous statistical methods than findings on Gold Choice[SM].

3.1 PFFS Plan Experiences

As a new Medicare program, PFFS has been shaped both by the federal government, through legislation and regulation, and by the objectives and actions of firms that have been approved to sell PFFS products.

This discussion of PFFS plan experiences synthesizes data and findings from several sources:

- Case studies of Sterling and Humana
- Sterling Option I[SM] and Humana Gold Choice[SM] market area studies, internet sites and other sources
- Medicare EDB and M+C data describing Option I[SM] and Gold Choice[SM] enrollment trends,[9]
- Analyses of Option I[SM] market entry

3.1.1 Sterling Option I[SM]

Sterling entered the PFFS program with limited prior experience with the Medicare Plus Choice program. Before the Balanced Budget Act authorized M+C, Sterling's Medicare experience was confined to Medicare supplemental insurance (Medigap) marketed to individual beneficiaries. Sterling had no prior direct experience with the Medicare program. In May 2000, Sterling added Option I[SM] to a suite of products that included standard Medigap insurance with no restrictions on choice of provider (Sterling Premier[SM]) and lower-premium Sterling Select[SM] that restricted policyholders to Sterling's provider networks. Option I[SM] remains Sterling's only M+C (now Medicare Advantage) product.

When it was first offered, Option I[SM] expanded on Original Medicare by offering coverage while traveling, reducing co-payments for inpatient stays and skilled nursing facility (SNF) visits, and protecting against out-of-pocket costs for outpatient care and services. Original Medicare was more generous in coverage than Option I[SM] in certain areas: for example, durable medical equipment (20 percent co-insurance, compared to 50 percent for Option I[SM]) and home health (no cost-sharing, compared to 35 percent co-insurance for Option I[SM]).

Sterling's Objectives for Option I[SM]

Based on marketing materials available on Sterling's corporate website, Sterling viewed Option I[SM] as a product that should appeal to beneficiaries who wanted freedom to choose their own providers in a fee-for-service environment similar to Original Medicare but who also wanted a plan that was less expensive than standard Medigap products.

[9] http://www.cms.hhs.gov/healthplans/statistics/geos/ ; http://www.cms.hhs.gov/healthplans/rates/

Marketing Option I[SM] [10]

Initially, Sterling's marketing and sales tactics varied across the Option I[SM] service area. Sterling marketed and sold Option I[SM] policies from its home office in Bellingham Washington (now Glenview, Illinois) and through a network of Sterling sales agents. Sterling agents sold all three of Sterling's Medicare products.

Stakeholders interviewed for the evaluation held a wide range of views, both positive and negative, about Sterling's approach to marketing Option I[SM]. Perceptions varied across markets within the Option I[SM] service area, perhaps reflecting the importance both of Sterling's local corporate image and of how agents presented Option I[SM] to beneficiaries and providers. For example, in Louisiana in 2002, a state insurance commission representative theorized that Sterling's smooth entry into the Baton Rouge area might have been aided by the fact that the company had previously sold Medigap policies in the area, making them a known commodity. The Louisiana SHIP director noted that, at least initially, Sterling's sales agents were telling beneficiaries that if they were not satisfied with Option I[SM,] they could readily switch to other Sterling Medicare products. In contrast, there was some initial confusion when Option I[SM] was first introduced in the Austin-San Marcos (Texas) area. Local informants alleged that, initially, Sterling agents had apparently told beneficiaries that providers were required to accept Option I[SM], when in fact providers were free to choose whether or not they would accept Option I[SM]. Stakeholders reported no continued evidence of confusion in the second round of market interview.

In 2002, some stakeholders also credited market disruptions caused by exits and general uncertainty surrounding M+C MCO plans, as well as general absence of M+C alternatives, with shaping Sterling's earliest marketing techniques. For example, in Pennsylvania and Tennessee, Sterling stakeholders alleged that linked its initial marketing efforts to HMO exits. Stakeholders also commented that information about Option I[SM] was included in the plan termination letters that were mailed to MCO enrollees (a CMS requirement for termination letters), and Sterling agents conducted additional outreach to these involuntary disenrollees from exiting MCOs. However, Sterling was not reported to have targeted MCO disenrollees in other sites. Additionally, in subsequent interviews with stakeholders conducted in 2004, no informants suggested that Sterling targeted disenrollees, even though MCO exit continued to be an issue in some areas.

Despite statistical evidence that Option I[SM] has enrolled more disabled beneficiaries than one would expect based on their numbers in the total Medicare population[11], no stakeholder interviewed for this evaluation suggested that Sterling had deliberately targeted beneficiaries with disabilities. In fact, in 2004, two of three advocates for persons with disabilities interviewed were not familiar with Option I[SM]. Some informants agreed that Option I[SM] might be appealing to persons with disabilities. A representative from a national organization that advocates for persons with disabilities had not heard of PFFS but offered the opinion that Option I[SM] could be attractive to persons with disabilities who were not yet eligible for Medicaid. A SHIP counselor commented that Option I[SM] would be attractive to persons with disabilities who had been unable to purchase supplemental insurance.

Changes in Option I[SM]

Initially, Sterling sold Option I[SM] policies with the same premium and benefit structure throughout its service area of rural and urban counties in 25 states. Over the four years of this study, Sterling reduced and re-configured the Option I[SM] service area (now segmented into three areas), changed

[10] Information in this section comes from market area interviews with stakeholders and interviews conducted in 2003 with three Sterling sales agents (names provided by Sterling).

[11] See Section 3.5.1, below

premium levels, and re-structured the benefit. Exhibit 3.1 summarizes some key service area changes between 2002 and 2004.

Option I[SM] service area and enrollment: Sterling Option I[SM] experienced phases of rapid expansion and contraction in service area (and enrollment) over the four years of the evaluation:

> Expanding service area, with rapid enrollment growth (July 2000 through September 2001): Option I[SM] grew in this period from zero to 17,362 enrollees. Key factors involved in early growth were: 1) an increase in the number of states in the Option I[SM] service area, from 17 to 25, and 2) a surge in enrollments in early 2001, due to a wave of involuntary disenrollments from other M+C plans in 2000,
>
> Growth and contraction of service area, and a reversal of enrollment growth trends (October 2001 through December 2003): Option I[SM] enrollment peaked at slightly more than 20,000 enrollees in mid-2002, followed by a slow but steady decline to 16,441 in December 2003. In 2002, Sterling added Montana to its service area but exited from the state of Mississippi and nine counties in Texas. In 2003, Option I[SM] made no additions to its service area, but exited from 30 counties in Louisiana, Ohio, Tennessee and Texas.
>
> Contracting service area, with continued enrollment decline followed by recovery (January 2004 through September 2004): In 2004, Sterling Option I[SM] exited from 502 counties in Alaska, Arkansas, Arizona, Illinois, Louisiana, Nevada, Ohio, Oklahoma, Oregon, South Carolina, Texas, Utah and the entire state of West Virginia. As a result, Option I[SM] was available to 4 million fewer eligible Medicare beneficiaries in 2004 than in 2003, a contraction of about 28 percent. These exits also meant that 2,542 Medicare beneficiaries were involuntarily disenrolled from Option I[SM].
>
> By reducing its service area, Sterling achieved a slight increase in market penetration. With 16,441 enrollees in December 2003, 0.11 percent of eligible beneficiaries in the service area owned Option I[SM] policies. By March 2004, even with further contraction to 15,400 enrollees, the Option I[SM] share had increased to 0.15 percent. By September, absolute numbers of enrollees had increased (to 17,353) within the smaller service area, and the Option I[SM] penetration rate had also increased slightly, to 0.16 percent.

Exhibit 3.1: Sterling Option I[SM] Service Area: 2002 and 2004

Item	2002	2004
States	25	23
All Counties	1,650	1,022
Urban floor	202	147
Rural floor	1,167	727
Medicare beneficiaries with access to Option I[SM]	14.73 million	10.45 million
Option I[SM] enrollment	19,762	15,400
Option I[SM] market penetration	0.13%	0.16%

Source: *http://www.cms.hhs.gov/healthplans/statistics/geos/*, *http://www.cms.hhs.gov/healthplans/rates/*

Service area contraction slightly increased the proportion of Option I[SM] counties eligible for floor payments. In 2003, 83 percent of Option I[SM] counties were floor counties. Of these, 15 percent were urban and 85 percent rural. In 2004, 85 percent of the smaller service area were floor counties. The share of urban floor counties increased slightly, to 17 percent, and there was a corresponding decrease in the rural floor county share to 83 percent.

Premium: From 2000 to 2003, the Option I[SM] monthly premium increased 60 percent, from $55 to $88. Then, in 2004, Sterling defined three service areas, with different premiums for each area: $68 per month (Area 1), $48 per month (Area 2) and $78 per month (Area 3). [12]

Benefit design: In 2004, Sterling modified certain features of the Option I[SM] benefit. (See Exhibit 3.2) Some important changes were the following:

- Initially, inpatient hospital coverage had been subject to an inpatient deductible but no co-payments. In 2004, the deductible was removed, and co-payments, keyed to the three new Option I[SM] market areas, were added for the first five days of an inpatient stay.

- Skilled nursing facility (SNF) stays initially required co-payments of $25/day for the first 100 days. In 2004, co-payments were eliminated for the first 10 days, but retained for days 11 through 100.

- Initially, Option I[SM] enrollees paid $20 per physician visit, for both primary and specialist services. In 2004, co-payments for primary care visits were reduced to $15. For specialist visits, co-payments increased to $30 (Area 1) and $35 (Areas 2 and 3).

The history of Option I[SM], particularly between 2003 and 2004, suggests that Sterling made refinements designed to reduce its risk exposure. In particular, Sterling implemented a major consolidation of the Option I[SM] service area, without experiencing a correspondingly large decline in enrollment. The new three-tiered system of premiums implies that, with three years' experience, Sterling may have acquired more accurate information on geographic variation in costs and risks than it had when it introduced Option I[SM] to the market. Changes to cost sharing formulas suggest Sterling's greater understanding of how costs vary among enrollees. Originally, enrollees paid the same flat rate for primary and specialist care. Now, enrollees incur higher co-payments for specialist care. Enrollees used to pay a deductible for each hospital stay, but no co-payments. Now, with no deductible but with co-payments for the first five days, enrollees who are hospitalized for relatively minor procedures will have a financial incentive to shorten their stays.

[12] Option I[SM] market areas in 2004:

Area 1 – Delaware, Idaho, Nebraska, Nevada (some counties), New Mexico, Oregon (some counties), Pennsylvania, Utah (some counties), Washington

Area 2 – Arizona (some counties), Iowa, Louisiana (some counties), Minnesota, Oklahoma (some counties), South Dakota (some counties)

Area 3 – Arkansas (some counties), Illinois (some counties), Kentucky, Montana (some counties), Ohio (some counties), South Carolina (some counties), Tennessee (some counties), Texas (some counties)

Exhibit 3.2: Sterling Option I[SM] Benefit: Selected Changes (2002 and 2004)

Item	2002	2004
Monthly premium	$58.70 (Part B) plus $78(Option I[SM])	$66.60(Part B) plus $68 (Area 1) $48 (Area 2) $78 (Area 3)
Inpatient hospital	Deductible: $350 No co-payments	Deductible: None Co-payments: (days 1-5) $100/day (Area 1) $150/day (Areas 2,3)
Skilled nursing facility	Co-payments: $25/day	Co-payments: Zero (days 1-10) $25/day (days 11 - 100)
Home health	Co-insurance: 35%	Co-insurance: 25%
DME	Co-insurance: 50%	Co-insurance: 40%
Primary care*	Co-payment: $20/visit	Co-payment: $15/visit
Specialist care*	Co-payment: $20/visit	Co-payment: $30/visit (Area 1) $35/visit (Areas 2,3)

Source: Sterling Option I[SM] 2002 Summary of Benefits; Sterling Option I[SM] 2004 Summary of Benefits

* Like other PFFS plans, Option I[SM] does not permit balance billing.

3.1.2 Humana Gold Choice[SM]

Humana Inc.'s association with the Medicare program began in 1987. Since passage of the Balanced Budget Act in 1997, Humana has been one of the largest M+C participants. In 2002, Humana enrolled 350,000 Medicare beneficiaries (six percent of all M+C enrollees) in its managed care plans, concentrated in Florida, Illinois, Texas, Arizona Missouri and Kansas. Humana competes in the commercial market for individual health insurance. In 2004, Humana was approved to sell Medigap products in Illinois, Texas, Arizona and Missouri.

Humana's experience with PFFS began in 2002, with a CMS-approved demonstration of Gold Choice[SM] in DuPage County Illinois. Humana proposed the demonstration as a way of offering coverage for beneficiaries left uncovered after Humana's M+C HMO exited the county. In 2003, CMS approved Humana's Gold Choice[SM] product for sale throughout what the company termed the "Midwest Region" (Iowa, Minnesota, Wisconsin and parts of North and South Dakota). CMS also renewed its approval of the DuPage County demonstration.

Humana's Objectives for Gold Choice[SM]

Humana officials asserted that their primary objective for Gold Choice[SM] was to offer more choices to seniors, particularly in rural areas. PFFS was considered attractive because there were no overhead costs involved in building contracted provider networks. In designing the Gold Choice[SM] service area, Humana looked for favorable combinations of reimbursement, administrative costs and claims costs. Counties with floor payments were deemed particularly attractive. Having found clusters of

counties with attractive financial profiles, Humana then "glued together" contiguous counties to build a cohesive market area.

The Gold Choice℠ Benefit

Initially, Humana marketed a single individual Gold Choice℠ product, with a premium of $19 per month. Gold Choice℠ differed from Original Medicare in several ways (See Exhibit 3.3):

- Co-payments (early in a stay), but no deductible, were charged for inpatient hospital services - Original Medicare charges a deductible, and imposes co-payments after day 60.
- Co-payments were charged after day 21 in a skilled nursing facility stay, while Original Medicare charges higher per-day co-payments from the day 21.
- Gold Choice℠ enrollees were not at risk for excess charges from physicians who did not accept assignment.
- Gold Choice℠ included outpatient prescription drug coverage with no cap, and with a tiered system of co-payments designed to encourage use of generic drugs.
- Gold Choice℠ offered its members a form of catastrophic coverage, with an annual $5,000 cap on out-of-pocket spending.

Of course, Medicare beneficiaries could buy Medigap plans that would pay deductibles and other cost sharing amounts, including excess physician costs. However, at the time, Gold Choice℠ offered two benefits not available through any Medigap plan: drug coverage without a cap, and catastrophic coverage.[13]

In 2004, Humana began marketing two PFFS products to individual beneficiaries: Gold Choice℠ Standard and Gold Choice℠ Value. Beneficiaries paid a higher premium for Value ($79 per month, compared to $29 per month for Standard), and were liable for higher initial co-payments for inpatient and skilled nursing facility care. However, Gold Choice℠ Value policyholders paid lower co-payments for most physician and other outpatient services, and enjoyed a richer prescription drug benefit.

[13] Two new standard Medigap plans, authorized in the MMA, include annual limits on out-of-pocket spending of $2,000 and $4,000.

Exhibit 3.3: Humana Gold Choice[SM] and Original Medicare + Medigap Benefits (2003)

Item	Humana Gold Choice[SM]	Original Medicare + Medigap Plan I
Monthly premium	$58.70 (Part B) plus $19(Gold Choice[SM])	$58.70/month (Part B) plus Medigap (varies)
Inpatient hospital	Deductible: none Co-payments: Days 1 - 5: $150/day Days 6 - 150: none	Deductible, co-payments: paid
Skilled nursing facility	Deductible: none Co-payments: Days 1-20: none Days 21 - 100: $75/day	Co-payments: paid
Home health	Deductible, co-payments: none	Deductible, co-payments: none
DME	Deductible; none Coinsurance: 25%	Deductible; $100/year Coinsurance: paid
Physicians/other health professionals	Deductible: none Co-payments: Primary/outpatient: $15/visit ER: $50/visit Urgent care: $15-$50/visit Specialists: $25/visit Excess charges: none	Deductible: $100/year Coinsurance, excess charges: paid
Prescription drugs	Brand name drugs: Covered by Original Medicare: Coinsurance: 20% Not covered by Original Medicare Humana pays $10/prescription up to 30-day supply Generic drugs: Co-payment: $10/prescription up to 30-day supply Co-payment: $30/prescription up to 90-day supply through mail-order pharmacy	A few cancer medications Deductible: $100/year Coinsurance: paid Basic Plan I benefit: $1,250 limit
Foreign travel	World-wide coverage Deductible: $250/year Coinsurance: 20% 60 consecutive days of travel Annual maximum: $25 thousand	Foreign travel emergency: (plans C-J) Deductible: $250 Coinsurance: 20% 60 consecutive days of travel Lifetime maximum: $50 thousand
At-home recovery	No coverage	Up to $40/visit, $1,600 maximum
Preventive services	Generally same as Original Medicare	Routine hearing, vision, physical

Exhibit 3.3: Humana Gold Choice[SM] and Original Medicare + Medigap Benefits (2003)

Item	Humana Gold Choice[SM]	Original Medicare + Medigap Plan I
		exams (no coverage) No coinsurance or 20% coinsurance for covered exams and screening procedures
Annual cap on out-of-pocket spending	$5,000, with restrictions[3]	None

Source: Humana Gold Choice[SM] 2003 Summary of Benefits for the Midwest Region.

Marketing Gold Choice[SM]

Humana executives viewed Gold Choice[SM] as competitive with Medigap insurance. They did not expect that Gold Choice[SM] would attempt to compete with other M+C plans[14], including Option I[SM], in markets where the two co-existed.

Humana marketed Gold Choice[SM] through education and outreach to individual beneficiaries and providers throughout its service area. Gold Choice[SM] enrollees who participated in focus groups in Des Moines and Milwaukee described their experiences with a range of Humana marketing tactics, including advertisements (print and electronic), newspaper ad, and a direct mail notice. Several participants responded to phone solicitations from Humana, followed by in-home visits from Humana representatives. Others learned about Gold Choice[SM] from various sources, including a SHIP counselor and participants' employers

A dedicated unit in the corporation (Humana Marketpoint) managed sales and enrollment. Early barriers to plan growth included widespread unfamiliarity with PFFS, resistance to "change in general" from beneficiaries long familiar with Medigap products, and negative reactions to some features of the plan. For example, Humana executives noted that some beneficiaries viewed inpatient co-payments negatively. However, Humana executives also pointed out that beneficiaries found other features to be particularly attractive. Through early consumer preference analyses, Humana had determined that potential enrollees placed a high value on outpatient prescription drug coverage. According to Humana officials, this feature proved to be a major selling point for the plan, along with low premiums (relative to Medigap), and freedom to choose providers.

Despite Humana's outreach efforts, interviews with stakeholders in two MSAs in the Gold Choice[SM] service area (Des Moines Iowa and Milwaukee Wisconsin) revealed general unfamiliarity with the plan (three of six contacted had any knowledge of Gold Choice[SM]). Two representatives of a hospital association commented that they had seen advertisements for Gold Choice[SM]. The hospital association respondent from Iowa added that association members had reported some beneficiary confusion about the plan and marketing materials.

Although Humana also offered a Gold Choice[SM] product for groups, during the first year, marketing activity lagged well behind efforts to sell policies to individual Medicare beneficiaries. Early resistance among employers and other group purchasers seemed based partly on suspicions of the M+C program and its recent history of instability, and on a belief that Original Medicare might be a better option in a menu of choices for retirees. Humana hoped to build a customer base with

[14] In general, Humana did not offer Gold Choice[SM] in areas served by other Humana Medicare programs (HMOs and demonstration PPOs).

employers, labor unions and public sector entities that knew (and in some cases offered their employees) Humana's commercial insurance products. Humana also hoped that the product would appeal to more recent retirees whose employers had capped their health benefits contributions.

Trends in Gold Choice^{SM} Enrollment

The Gold Choice^{SM} five-state market area did not change from January 2003 through mid-2004.[15] During that period, growth in numbers of Gold Choice^{SM} enrollees has been slow but steady.[16] By December 2003, total enrollment increased from zero (February 2003) to 3,164 out of nearly 4.0 million eligible individuals in the Midwest Region, a penetration rate of 0.08 percent. In September 2004, Gold Choice^{SM} enrollment had reached 11,590 of 5.2 million eligible individuals, a penetration rate of 0.22 percent. Thus, though plan enrollment grew rapidly in percentage terms over its first year and three-quarters, total penetration of the market in Humana's service area remained well below one percent.

3.2 PFFS Enrollment and Disenrollment

Understanding beneficiary decisions to enroll in or disenroll from PFFS plans is important for two reasons. First, this information may have practical relevance for plan managers and government program officers who are charged with designing and marketing an attractive benefit. Second, data on characteristics of enrollees and disenrollees can shed light on possible selection bias in PFFS, suggesting whether or not PFFS plans attract beneficiaries at higher or lower risk than the average. This section addresses enrollee and disenrollee behavior. Section 3.5 describes enrollee and disenrollee characteristics, in the context of an analysis of selection issues.

This section synthesizes the findings from analyses of three primary data sources:

- Respondents to the National Enrollee Survey of a sample of Sterling Option I^{SM} enrollees and disenrollees and a comparison group of Original Medicare and M+C beneficiaries living in the Option I^{SM} service area).
- Option I^{SM} disenrollees who responded to the Research Triangle Institute's 2002 Medicare Satisfaction Survey – DR (Disenrollment Reasons), a survey module of CAHPS ® (Consumer Assessment of Health Plans).
- Two focus groups of Humana Gold Choice^{SM} enrollees.

3.2.1 Sterling Option I^{SM}

The Enrollment Decision

Cost and freedom of choice were important factors in beneficiaries' choice of Option I^{SM}. (Exhibit 3.4) Over half of all Option I^{SM} and Original Medicare respondents to the Enrollee Survey cited freedom of choice as a reason for selecting their current insurance (in contrast to only 13 percent of M+C enrollees). Cost was also important, but less so.[17] About 46 percent of Option I^{SM} enrollees

[15] In August 2004, Humana was approved to market Gold Choice^{SM} in six additional states: Georgia, North Carolina, South Carolina, Tennessee, Utah and Arizona.

[16] Enrollment counts in this section come from Medicare Managed Care Geographic Service Area Report http://www.cms.hhs.gov/healthplans/statistics/geos/

[17] Atherly and his colleagues have shown that premium levels are significant predictors of enrollment throughout the M+C program, but that the effects are concentrated among low-income beneficiaries. A.

mentioned cost as a reason for enrollment, more than Original Medicare (29 percent) but fewer than M+C (64 percent). About 30 percent of enrollees stated that Option I[SM] was the only plan available to them.

Exhibit 3.4: Reasons for Choosing Current Insurance: Option I[SM] Enrollees, Original Medicare, Other M+C

Measure	Enrollees	Original Medicare	Other M+C
Freedom of choice	54.6%	53.8%	12.5%
Cost	45.9	28.8	63.7
Only plan available	30.2	25.2	19.1
Other	9.2	14.1	31.3

Source: Sterling Option I[SM] National Enrollee Survey (July-December 2002) Database

Aged and disabled enrollees differed in their reasons for selecting Option I[SM]. (Exhibit 3.5) Disabled enrollees were less likely to mention freedom of choice (47 percent, compared to 57 percent of aged) or cost (38 percent, compared to 48 percent). For disabled beneficiaries, the most important reason for selecting Option I[SM] was that it was the only plan available (52 percent, compared to 23 percent of aged enrollees).

Exhibit 3.5: Reasons for Choosing Option I[SM]

Measure	Aged Option I[SM]	Disabled Option I[SM]
Freedom of choice	57.1%	46.5%
Cost	48.2	38.2
Only plan available	23.2	52.4
Other	10.3	7.3

Source: Sterling Option I[SM] National Enrollee Survey (July-December 2002) Database

Among those who knew about Option I[SM] but decided not to enroll, satisfaction with current insurance was the principal reason for not making a change (49 percent). (Exhibit 3.6) Two additional reasons for not enrolling were concern that providers would not accept Option I[SM] (46 percent) and a perception that the co-payments were too high (39 percent).

Atherly, B. Dowd and R. Feldman. (August 2004) The effect of benefits, premiums and health risk on health plan choice in the Medicare program. *Health Services Research.* 39:4, Part 1: 847-864.

Exhibit 3.6: Reasons for Not Choosing Option I[SM]

Measure	All	Original Medicare	M+C
No need to change; current insurance OK	49.2%	33.4%	71.7%
Co-payments seemed too high	39.3	17.7	70.0
Lesser coverage than other options	26.3	37.8	9.9
Advised against Option I[SM]	9.6	15.3	1.6
Concerned about provider acceptance of Option I[SM]	45.8	34.0	62.4
Other	10.0	14.2	4.0

Source: Sterling Option I[SM] National Enrollee Survey (July-December 2002) Database

Sources of Information for Enrollment Decision-making

In the National Enrollee Survey, well over 90 percent of enrollees, disenrollees and a comparison group of other Medicare beneficiaries living in the Option I[SM] service area professed no knowledge of Option I[SM]. Of those who did know something about Option I[SM,] over 25 percent of enrollees and comparison group members had learned of it from Medicare's handbook *Medicare and You.* Print and electronic advertising were also frequently cited. Family and friends were a source for around 20 percent of enrollees. Few had learned of the program from local SHIP counselors or from providers.

When asked who recommended Option I[SM] to them, most (about 80 percent) mentioned Sterling sales agents. About 20 percent had attended Sterling presentations. Nearly half of current enrollees said that they had received no recommendations from anyone.

The Decision to Disenroll

In the National Disenrollee Survey, most M+C disenrollees cited as reasons for leaving at least one problem related to costs (excessive premium, co-payment) or to benefits (benefits better in another plan). But problems of costs and benefits were more likely to be mentioned by Option I[SM] disenrollees than by disenrollees from other M+C plans, after adjusting for other factors. Problems with doctors and other providers, and a broad range of access problems were less important reasons for leaving Option I[SM] than they were for leaving other M+C plans. However, problems with the amount or accuracy of information provided by plans were more important for Option I[SM] disenrollees.

3.2.2 Humana Gold Choice[SM]

The Enrollment Decision

Lacking data from a national Gold Choice[SM] survey, evaluators had to rely on perceptions of Humana program managers and Gold Choice[SM] enrollee participants in four focus groups to assess beneficiaries' enrollment decisions.

Humana managers' responses to the question, "Why do beneficiaries decide to enroll in Gold Choice[SM]?" included several possibilities (not necessarily in order of importance): 1) low premium, 2) filled some of the gaps in traditional Medicare coverage, 3) some level of prescription drug coverage, 4) predictable co-payments, and 5) freedom to choose providers.

A low-cost premium was by far the most important reason why focus group participants purchased Gold Choice[SM] policies. Most participants (18 of 27 who volunteered information about their previous insurance) had switched from other private (non-HMO) insurance coverage to Gold Choice[SM]. This finding supports observations of Humana management that Gold Choice[SM] has used low premiums to compete with Medigap products, not with other M+C plans. Stakeholders tended to share this view of the Gold Choice[SM] "price advantage." Interestingly, no focus group participant singled out the prescription drug benefit as an attractive selling point for Gold Choice[SM].

According to Humana executives, what beneficiaries appeared not to like were 1) the inpatient co-payments and 2) "change in general." On this last point, managers observed that many beneficiaries in the Midwest have bought and been familiar with Medigap products for years, and could be expected to respond cautiously to new offerings like Gold Choice[SM]. Humana also reported skepticism on the part of some beneficiaries who believed that the PFFS product at the offering premium was "too good to be true."

3.3 PFFS Impacts on Enrollees

PFFS may affect enrollee access to services, out-of-pocket costs, and satisfaction (with care, with plan procedures). To assess enrollee impacts, the evaluation used both standard quantitative estimates of PFFS effects, contrasting enrollees to comparison groups of beneficiaries, and qualitative information. Data used included:

- The National Enrollee Survey (Option I[SM]).
- The RTI Disenrollment Reasons Survey (Option I[SM]).
- Market area stakeholder interviews (Option I[SM] and Gold Choice[SM]).
- Enrollee focus groups (Gold Choice[SM]).

3.3.1 Sterling Option I[SM]

Access and Costs

Perceptions varied on whether or not Option I[SM] enrollees encountered barriers to accessing covered services. In early stakeholder interviews, one local SHIP coordinator reported having heard of some instances when Option I[SM] enrollees had difficulty accessing providers. Stakeholder interviews also uncovered a few reports of providers refusing to be deemed for Option I[SM.]

High out-of-pocket costs, whether incurred or expected, can pose a barrier to access, even though some stakeholders and beneficiaries interviewed for this study viewed them as separate problems. Because beneficiaries in Original Medicare, with or without Medigap coverage, had never encountered co-payments for home health and certain other services, some stakeholders interviewed for the study worried that enrollees would be surprised by higher-than-expected out-of-pocket costs.

Some stakeholders' perceptions about beneficiary cost concerns with PFFS proved to be accurate. In fact, Option I[SM] disenrollees cited high costs as one of the most important reasons for leaving the plan. Among Medicare beneficiaries contacted in the National Enrollee Survey, cost was more often seen as a problem with access implications by Option I[SM] enrollees.(Exhibit 3.7) Nearly 69 percent of Option I[SM] enrollees reported paying more for care this year than last, compared to 48 percent of Original Medicare and 42 percent of other M+C beneficiaries. Option I[SM] enrollees were more likely than Original Medicare beneficiaries to report that costs forced them to delay care.

Exhibit 3.7 Adjusted[1] Measures of Access to Health Care Services: Current Option I[SM] Enrollees Compared to Original Medicare and M+C

Measures	Current Option I[SM] Enrollees	Original Medicare	M+C
Paying more for care than last year	68.6%	48.3%***[2]	42.3%**[2]
Delayed or didn't get care -- couldn't afford it	13.1	9.8**	11.2
Trouble getting any insurance accepted	4.9	5.0	2.9
Two or more health care needs	13.5	14.5	6.9**
Needed but didn't get care for cost reasons	10.0	7.1**	6.4
Needed specialist care	47.0	51.9	49.7
Needed/didn't get specialist care	4.1	2.8	3.5
Needed hospital care	11.2	12.9	4.6**
Needed/didn't get hospital care	0.4	0.4	0.4
Needed medical equipment	5.9	6.7	2.6**
Needed/didn't get medical equipment	12.2	4.7*	1.5
Needed home health care	2.4	2.6	3.6
Needed/didn't get home health	4.2	0.5	0.0

Source: Sterling Option I[SM] National Enrollee Survey (July-December 2002) Database

1 Weighted logistic regression adjustment: control variables include age, gender, race/ethnicity, education, living arrangement, ever/current disability status

2 Statistical significance of Current Option I[SM] Enrollees minus (Original Medicare or M+C) estimates:

* 0.10>=p>0.05
** 0.05>=p>0.01
*** 0.01>=p

Enrollees did not frequently identify access to specific services as a problem for Option I[SM]. There were few differences between Option I[SM] and other Medicare beneficiaries in needs for care or in the frequency of specific unfulfilled needs. Durable medical equipment (DME) was an exception. Only three to six percent of surveyed beneficiaries reported needing DME. However, of those with a DME need, Option I[SM] enrollees were more likely than others to have had this need unfulfilled (12 percent, compared to five percent for Original Medicare beneficiaries. There was no significant difference between Option I[SM] and other M+C in DME access.

As Exhibits 3.8 and 3.9 show, disabled beneficiaries were more likely to report access problems than aged beneficiaries. However, there was little evidence for any difference between disabled and aged respondents in Option I[SM] effects. With the exception of unfilled needs for home health care (there were none reported by disabled beneficiaries) all measures of perceived need and barriers to access were larger for disabled beneficiaries, whether in Option I[SM] or in other plans. However, in only two instances were Option I[SM] effect measures statistically significant, in either group.

- A relatively larger proportion of both disabled and aged Option I[SM] enrollees reported paying more for health care this year (69 percent, against 39 percent for other disabled beneficiaries, and 64 percent against 44 percent for other aged beneficiaries, respectively).

- Needs for specialty care were lower among aged beneficiaries in Option I[SM] (expressed by 37 percent of Option I[SM] aged enrollees, and 43 percent of aged other beneficiaries). There was no difference for disabled beneficiaries. No other differences on access questions were statistically significant.

Exhibit 3.8 Adjusted[1] Measures of Access to/Use of Services: Disabled Beneficiaries

Measures	All Option I[SM] [2]	All Others	All Option I[SM] - All Others [3]
Paying more for care than last year	69.1%	39.2%	29.9pp***[4]
Delayed or didn't get care -- couldn't afford it	35.1	30.2	4.8
Trouble getting any insurance accepted	11.9	10.8	1.1
Two or more health care needs	22.6	19.5	3.1
Needed but didn't get care for cost reasons	24.9	17.4	7.5
Needed specialist care	63.1	63.1	0.0
Needed/didn't get specialist care	3.4	3.6	(0.2)
Needed hospital care	17.2	18.0	(0.8)
Needed/didn't get hospital care	0.8	0.7	0.1
Needed medical equipment	10.9	8.1	2.8
Needed/didn't get medical equipment	14.1	5.1	9.0
Needed home health care	4.2	8.7	(4.5)
Needed/didn't get home health	--[5]	--[5]	--[5]

Source: Sterling Option I[SM] National Enrollee Survey (July-December 2002) Database

1 Weighted logistic regression adjustment: control variables include age, gender, race/ethnicity, education, living arrangement, ever/current disability status.

2 Current enrollees plus disenrollees

3 Negative values in parentheses

4 Statistical significance of All Option I[SM] minus All Others estimates:

* 0.10>=p>0.05
** 0.05>=p>0.01
*** 0.01>=p

5 Regression estimates were unreliable, due to small sample sizes.

Exhibit 3.9 Adjusted[1] Measures of Access to/Use of Services: Aged Beneficiaries

Measures	All Option I[SM] [2]	All Others	All Option I[SM] - All Others [3]
Paying more for care than last year	64.3%	44.0%	20.3pp***[4]
Delayed or didn't get care -- couldn't afford it	11.0	9.0	2.0
Trouble getting any insurance accepted	2.7	2.3	0.4
Two or more health care needs	7.6	7.3	0.3
Needed but didn't get care for cost reasons	7.4	6.4	1.0
Needed specialist care	37.0	43.1	(6.1)*
Needed/didn't get specialist care	3.0	2.9	0.1
Needed hospital care	6.6	5.8	0.8
Needed/didn't get hospital care	0.5	0.7	(0.2)
Needed medical equipment	4.5	4.0	0.5
Needed/didn't get medical equipment	12.8	4.8	8.0
Needed home health care	2.4	2.0	0.4
Needed/didn't get home health	--[5]	--[5]	--[5]

Source: Sterling Option I[SM] National Enrollee Survey (July - December 2002) Database

1 Weighted logistic regression adjustment: control variables include age, gender, race/ethnicity, education, living arrangement, ever/current disability status.

2 Current enrollees plus disenrollees

3 Negative values in parentheses

4 Statistical significance of All Option I[SM] minus All Others estimates:

* 0.10>=p>0.05
** 0.05>=p>0.01
*** 0.01>=p

5 Regression estimates were unreliable, due to small sample sizes.

Ability to access covered services was a less important reason for disenrolling from Option I[SM] than for leaving other M+C plans. Adjusted for other factors, Option I[SM] disenrollees were half as likely to cite access issues as other M+C disenrollees.

Satisfaction

Although few respondents to the National Enrollee Survey expressed dissatisfaction with their health insurance, Option I[SM] enrollees were somewhat less likely than others to be dissatisfied (four percent versus five percent). Similarly, few beneficiaries filed formal complaints with their plans. Option I[SM] enrollees were more likely than others to complain (12 percent versus 8 percent). At the same time, Option I[SM] enrollees had their complaints addressed more rapidly than other complainants. Of those who complained, the overall rate of satisfaction with how the complaints were handled was generally high and about the same for Option I[SM] and other Medicare beneficiaries.

Disabled beneficiaries were more likely to complain than aged beneficiaries, regardless of health insurance status. However, disabled Option I[SM] enrollees were less likely than others to have experienced lengthy delays or lack of resolution (27 percent, compared to 41 percent).

In the survey of M+C disenrollees, Option I[SM] respondents were less likely than others to have left their plan because of dissatisfaction with customer service. They were also less likely to have left

because of dissatisfaction with their health care. On the other hand, Option I[SM] respondents were more likely to have left because of general dissatisfaction with their health plan.

3.3.2 Humana Gold Choice[SM]

Access and Cost

Gold Choice[SM] enrollees in two focus groups reported few difficulties accessing physician services. (One enrollee in Des Moines had some trouble convincing her doctor to accept Gold Choice[SM]). Cost was rarely mentioned as an access barrier, although some argued that out-of-pocket costs under the Gold Choice[SM] prescription drug benefit were high, particularly for brand name drugs.

Satisfaction

Focus group participants reported diverse experiences in contacting Humana and getting problems resolved. Some cited problems that included complicated phone option menus and delays in responding to queries. Others, however, expressed satisfaction with both the speed and responsiveness of Gold Choice[SM] customer service representatives.

In general, focus group participants were satisfied with Gold Choice[SM]. All would recommend the plan to others (and three had already done so). Most planned to renew. The few that hesitated on a commitment to renew were waiting 1) to see what other options would be available through their former employers or 2) to see if Humana implemented increases in premiums or changes in the Gold Choice[SM] benefit.

3.4 PFFS Impacts on the Health Care System

Many stakeholders initially viewed PFFS as an insurance product that would principally attract beneficiaries in Original Medicare who wanted additional coverage, normally provided by Medigap insurance, and who valued freedom to choose providers. Therefore, PFFS' impact on the health care system could hypothetically be measured in terms of 1) changes in premiums, benefits and marketing strategies in the Medigap market and 2) changes in provider decisions to accept Medicare patients or to contract with non-PFFS M+C plans 3) increase in the number of initiatives among existing M+C organizations and others to offer new PFFS products.

For this evaluation, data were not available to support direct analyses of changes in the Medigap markets or in provider behavior. Instead, the evaluation had to rely on perceptions of stakeholders, gathered in Option I[SM] and Gold Choice[SM] market area studies, views about PFFS captured in interviews with national advocacy organizations, and observations of Gold Choice[SM] focus group participants.

Even were adequate data available, the odds of finding a measurable PFFS impact on the health care system would be low. PFFS has not been a substantial presence in any area of the US over the first four years of the program. Only within the last two years has there been evidence of growing interest in PFFS from health insurers other than Sterling or Humana. Overall, PFFS has attracted less than one percent of all eligible Medicare beneficiaries in the states and counties served by Option I[SM] and Gold Choice[SM.] In a majority of these counties, no one had enrolled in either plan during this period. And local stakeholders, with some exceptions, were uninformed throughout this period both about the details and often about the existence of PFFS options in their markets.

3.4.1 National Advocacy Organizations/Information Brokers

Two rounds of interviews with informants from national organizations revealed some technical concerns about PFFS but no sense that the program would have any major impacts, positive or negative, on their constituents. In 2002, some, including the American Association of Health Plans (AAHP) and the American Medical Association (AMA), supported the general idea of more choice in M+C (though the AMA expressed concerns about possible confusion among providers about deemed status). Nonetheless, respondents generally did not express strongly favorable views of PFFS. The Health Insurance Association of American (HIAA), the American Association of Retired Persons (AARP) and the AAHP all viewed PFFS as an unattractive business model. They believed that firms already involved in managed care would be unlikely to convert to, or add, a PFFS product. These firms would be more likely to move toward developing Preferred Provider Organizations (PPOs) for Medicare, a well-understood model with a history in private sector health insurance markets. The Medicare Rights Center saw PFFS as an attractive option only for disabled people living in states without guaranteed Medigap issue

Two years later, follow-up interviews continued to show minimal interest in and knowledge of PFFS among national organizations. Responding to data that showed high rates of enrollment in PFFS among disabled Medicare beneficiaries, the evaluation added the American Association for Persons with Disabilities to the list of interviewees. However, this association was not familiar with PFFS.

3.4.2 Local Market Stakeholders

In interviews, stakeholders in both Option I^{SM} and Gold Choice^{SM} service areas had little to say about the implications of PFFS for local market competition. Most commented on how providers perceived and reacted to the program.

Sterling Option I^{SM}

In 2002, stakeholders discussed potential and actual provider reactions to Option I^{SM} features such as deeming, contracting, and claims payment, and responses to Sterling's marketing and outreach. Perceptions of how providers would respond (and had, at this early stage, responded) varied among sites. HMO withdrawals appeared to have affected provider acceptance differently. Baton Rouge informants saw no negative effects -- physicians were seen accepting Option I^{SM} as if it were just another Medigap plan. However, stakeholders in Seattle and Austin acknowledged greater initial difficulty with provider understanding and acceptance, which they attributed partially to market disruptions caused by HMO exits. Most informants cited confusion over deeming, while at the same time noting that complaints and questions from providers had been few. Sterling's response to this early confusion among providers had been to implement a more proactive outreach policy. Stakeholders viewed this policy as relatively effective.[18]

Because Sterling sales agents initially focused more on outreach to potential enrollees, providers often learned about Option I^{SM} when their patients asked them to accept their new coverage. In most instances, however, rather than refusing to cooperate, providers appeared to have adapted by following up with queries to Sterling for more information. In Baton Rouge, contacts at a clinic and hospital described this process, and asserted that after having seen enough patients with Option I^{SM} coverage, both entities had developed procedures for dealing with them. Positive experience with Sterling's speed and efficiency in paying claims increased provider acceptance in many areas. In Nashville, one health care institution was working directly with Sterling to inform beneficiaries about Option I^{SM}

[18] For example, Sterling's home office in Bellingham Washington (now Glenview, Illinois) opened a special office on Provider Relations that handled direct calls from providers throughout the Option I^{SM} service area.

By 2004, provider concerns raised during interviews with stakeholders in 2002 had, for the most part, either not recurred or never materialized. In general, local provider groups had neither received complaints from providers nor had any further contact with Sterling or its sales agents.

Humana Gold Choice[SM]

Humana plan managers admitted that, they had initially underestimated the challenges of introducing Gold Choice[SM] both to beneficiaries and to providers. Early confusion over key PFFS features like deeming was widespread. In some instances, front desk staff in physicians' office were reported to have passed on incorrect information about Gold Choice[SM] to patients. Viewed by Humana managers, overall provider cooperation was excellent, once initial misunderstandings had been addressed. However, some providers in Iowa had declined to accept Gold Choice[SM] A SHIP counselor and hospital association representative in Iowa confirmed this fact, noting that rural Critical Access Hospitals (of which there are 57 in Iowa) could expect higher payments under that program than under PFFS. Additionally, Humana executives noted that certain providers in Minnesota and Wisconsin that belonged to networks of health plans offering competing products declined to accept Gold Choice[SM]

For Gold Choice[SM] enrollee focus group participants, provider participation in Gold Choice[SM] was not an issue. Most who used physician services found their doctors receptive to the program.

3.5 PFFS Impacts on the Medicare Program: Evidence for Selection

PFFS impact on the Medicare program represents the net increase or decrease in Medicare-covered costs of having the program in place, essentially the difference between M+C payments to PFFS plans and costs that PFFS enrollees would have incurred in other Medicare settings. If payment rates accurately capture the health risks of PFFS enrollees, then PFFS is cost neutral for Medicare.

Research literature addresses the hypothesis that the federal government has over-paid Medicare managed care plans because plans have enrolled Medicare beneficiaries who were healthier than beneficiaries who stayed with Original Medicare. (See R Brown, et al., Fall 1993; K Call, et al., Summer 1999; M. Aber and C. McCormick, Spring 2000) Historically, payment rates for MCOs were tied to average local fee-for-service costs of Original Medicare. MCOs attracted (and recruited) beneficiaries at lower than average risk for using health care services (favorable selection). [19] Since payment rates reflected fee-for-service costs, some MCOs were in a position to capture immediate profits on their healthier-than-average Medicare enrollment base. Over the long run, when average fee-for-service costs rose as healthy beneficiaries left Original Medicare, MCO payment rates would continue to rise. Of course, aging of MCO enrollee populations could attenuate early financial gains, unless disenrollment from plans was more frequent among high-risk enrollees.

Reforms introduced under the Balance Budget Act severed the direct connection between fee-for-service and MCO payment rates. However, despite the introduction of floor payment rates, a blended (local and national) payment rate formula and a mandate that CMS develop and implement a system for risk adjusting payments, concerns about selection remain.

This section addresses selection issues in two segments. The first segment compares demographic characteristics of enrollees and disenrollees to other Medicare beneficiaries, based on analyses of

[19] L Greenwald, et al. (Spring 2000) demonstrate favorable selection using PIP-DCG data. R. Feldman, et al. (Fall 2003) suggest that beneficiaries with different health risks are attracted to plans that meet their expected needs (for example, high-risk beneficiaries have been attracted to plans with prescription drug coverage).

Medicare EDB and market area data. The second compares health risks of Option I[SM] enrollees and disenrollees to other Medicare beneficiaries, based on self-reported data from the National Enrollee Survey and the National Disenrollee Survey.

3.5.1 Demographic Characteristics and Prior Insurance

Demographic characteristics. Early in the study period, Option I[SM] tended to enroll relatively young Medicare beneficiaries from rural and suburban counties, compared to Original Medicare and the rest of the M+C program in Option I[SM]'s service area. By 2003, with the exception of a high and growing percentages of disabled enrollees, the profiles of the average Option I[SM] and other M+C enrollees were more similar than they were in 2001. (Exhibit 3.10)

Exhibit 3.10: Demographic Characteristics: Option I[SM] vs. Other Medicare

Measure		Option I[SM] Enrollees	Other M+C	Original Medicare
Aged: over 85	(2001)	9%	13%	11%
	(2003)	11	13	12
Disabled	(2001)	19	15	7
	(2003)	25	15	6
Rural+ adjacent	(2001)	37	30	4
	(2003)	35	33	9
Lowest income qtile.	(2001)	13	10	2
	(2003)	10	9	2

Source: Sterling Option I[SM] Enrollment Analysis Database

- **The oldest of the old.** In 2001 in the Option I[SM] service area, nine percent of current age-eligible enrollees were 85 or older, compared to 13 percent (other M+C) and 11 percent (Original Medicare). By 2003, the Option I[SM] enrollee population had aged (11 percent over 85) to more closely resemble other M+C (13 percent) and Original Medicare (12 percent).

- **Disabled beneficiaries.** From 19 percent in 2001, the share of disabled Option I[SM] enrollees grew to 25 percent in 2003. Over the same period, the share of disabled beneficiaries in the Option I[SM] service area stayed the same (other M+C) or dropped slightly (Original Medicare).

- **Rural and adjacent counties.** In 2001 in the Option I[SM] service area, 37 percent of Option I[SM] enrollees lived in rural counties or counties adjacent to urban areas (compared to 30 percent of other M+C and four percent of Original Medicare). By 2003, Option I[SM] enrollees were less likely to live in rural and adjacent areas (35 percent), while rural shares for other M+C and Original Medicare had increased.

- **Lowest income counties.** In 2001 in the Option I[SM] service area, 13 percent of Option I[SM] enrollees lived in counties in the lowest quartile of the per capita income distribution, compared to 10 percent of other M+C and two percent of Original Medicare. By 2003, the percentages for Option I[SM] and other M+C were nearly identical (10 and 9 percent).

A relatively small number of Option I[SM] enrollees were part of state buy-in programs (1,139 out of 20,479, roughly 5.6 percent, in 2003). Compared to other Option I[SM] enrollees, this group was older, less likely to be white, more likely to live in low-income counties and more likely to live in counties with high PIP-DCG scores.

For the most part, persons who disenrolled from Option I[SM] resembled those who stayed enrolled. (Exhibit 3.11) Once again, however, disabled beneficiaries proved this rule. In 2001, only 10 percent of disenrollees were disabled, compared to 19 percent of current enrollees. By 2003, the difference remained, though it had narrowed somewhat (17 percent, compared to 25 percent).

Exhibit 3.11: Demographic Characteristics: Option I[SM] Enrollees vs. Disenrollees

Measure		Option I[SM] Enrollees	Option I[SM] Disenrollees
Aged: over 85	(2001)	9%	8%
	(2003)	11	10
Disabled	(2001)	19	10
	(2003)	25	17
Rural+ adjacent	(2001)	37	38
	(2003)	35	40
Lowest income qtile	(2001)	13	13
	(2003)	10	11

Source: Sterling Option I[SM] Enrollment Analysis Database

Prior insurance: Enrollees during the first and second year of Option I[SM] frequently came from other M+C plans that had reduced their service areas or withdrawn from the program. As Exhibit 3.12 shows, only 38 percent had been covered solely by Original Medicare during the six months before enrolling in 2001. Of the rest, 43 percent came after involuntary disenrollment from exiting M+C plans. Over time, the share of enrollees coming from Original Medicare increased, from 38 to 44 percent, while the share from closing M+C plans dropped, from 43 to 32 percent. Over the study period, disenrollees resembled enrollees in prior insurance status. However, among the newest enrollees, those who entered Option I[SM] late in 2002 and early in 2003, a clear majority came from Original Medicare (61 percent), while only 18 percent came from exiting M+C plans.

Exhibit 3.12: Prior Insurance: Option I[SM] Enrollees and Disenrollees

Measure	Enrollees (2001)	Enrollees (2003)	Newest Enrollees (2003)	Disenrollees (2003)
Original Medicare	38%	44%	61%	45%
Other M+C	62	56	39	55
(Exiting M+C)	(43)	(32)	(18)	(29)

Source: Sterling Option I[SM] Enrollment Analysis Database

3.5.2 Selection Effects: Relative Health Risks (Option I[SM] vs. Other Medicare)

Evidence on health risks comes from sources:

- Self reports of Option I[SM] and other Medicare respondents to the National Enrollee Survey
- Self reports of Option I[SM] and other M+C disenrollees in the National Disenrollee Survey
- County level risk scores from Medicare data

County-level data from the Option I[SM] service area suggest that early enrollees came from counties with relatively high average health risks for Medicare beneficiaries, based on PIP-DCG scores. In 2001, 14 percent of Option I[SM] enrollees lived in counties in the top quartile of the PIP-DCG score distribution (compared to 11 percent for Original Medicare and 8 percent for other M+C). However, that imbalance has diminished over time. By 2003, 11 percent of Option I[SM] enrollees lived in top quartile counties, lower than Original Medicare (12 percent) but still slightly higher than M+C (8 percent).

Based on data collected in the National Enrollee Survey, on average, Option I[SM] enrollees were no different from other Medicare beneficiaries in self-reported clinical, functional or health status measures, with two exceptions. Option I[SM] enrollees were more positive about their current health status and less pessimistic about their future health than other M+C or Original Medicare beneficiaries. Disabled enrollees were more likely to report severe limitations, chronic conditions, mental health limitations and poor health status than aged enrollees. Compared to other disabled beneficiaries, Option I[SM] enrollees reported more severe limitations but fewer chronic conditions. They were also much less likely to report deteriorating health status than their counterparts in other plans. Disenrollment may be removing persons at high risk from Option I[SM]. Disenrollees from Option I[SM] seemed to be more impaired and pessimistic than current enrollees, on every measure of health, function and health status. However, none of the contrasts between the two groups was statistically significant.

Data from the National Disenrollee Survey comparing Option I[SM] and other M+C disenrollees showed conflicting evidence on the question of whether Option I[SM] disenrollees were more likely than other M+C disenrollees to report health and functional problems of all kinds. Many simple contrasts of Option I[SM] and other M+C disenrollees suggested a positive answer. On mental health and mood questions, Option I[SM] respondents were consistently more likely to report higher frequency of problems. Option I[SM] respondents were also more likely to report multiple problems.

However, on closer inspection, it became clear that disability status was a key determinant of these patterns. Disabled disenrollees were nearly three times more likely to report problems than aged disenrollees. In addition, disabled beneficiaries were a larger percentage of total disenrollment from Option I[SM] than from other M+C plans (23 percent, compared to 9 percent). Thus after controlling statistically for disability status and certain other factors, it was discovered that the average Option I[SM] disenrollees was actually less likely on average to report multiple problems than other disenrollees.

4.0 Discussion

This report describes findings from the evaluation of PFFS separately for the two pioneering firms that offered PFFS products, Sterling and Humana. The authors have adhered to this format in order to emphasize the evaluation's limitations. As noted throughout, early evidence on PFFS performance and impacts are necessarily based mostly on the experience of Sterling Option I[SM]. Summaries of findings are presented separately for the two firms. Then, this report concludes with a brief discussion of possible future developments for PFFS in the environment created by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA).

4.1 Summary of Major Findings

4.1.1 Sterling Option I[SM]

Option I[SM] experienced cycles of growth and contraction during its first four years. Rapid Option I[SM] growth over the first two years seems to have been due at least in part to the simultaneous exits of other M+C plans in the service area. Contraction reflected a combination of a high voluntary disenrollment rate (as much as three times the rate of disenrollment from other M+C plans) and a Sterling's decision to exit from over 500 counties between 2003 and 2004.

Throughout the study period, Option I[SM] enrollment remained concentrated in a few states and counties; market penetration was low throughout the Option I[SM] service area. Initially, Option I[SM] enrollment was concentrated in Texas and Louisiana. By 2004, enrollment was distributed somewhat more evenly among states in the service area, but overall penetration never exceeded one percent of eligible beneficiaries in any state during the study period.

Stakeholders were initially confused about PFFS. However, providers seem to have accepted the program. Eligible beneficiaries, both enrolled and non-enrolled in Option I[SM], were confused about Option I[SM]. As late as 2004, some local stakeholders were unfamiliar with the program. Yet early evidence of resistance among some providers seems to have disappeared in market areas studied for the evaluation.

Compared to other M+C plans, Sterling enrolled a relatively young and rural enrollee population. Most early enrollees came from other M+C plans. Compared to the average beneficiary in Original Medicare or other M+C plans in the Option I[SM] service area, Option I[SM] enrollees tended to be white, young (among aged enrollees), more likely to be under age 65 and disabled, previously in another M+C plan, and living in rural counties. Over the study period, even though the enrollee population aged, the share of disabled enrollees increased. The proportion of Option I[SM] enrollees previously in Original Medicare increased as well.

Freedom of choice attracted enrollees to Option I[SM]. Option I[SM] respondents to the National Enrollee Survey were more likely than others to mention freedom to choose providers as a reason for enrollment. They were also more likely to note that Option I[SM] was the only insurance available to them.

There was no evidence of widespread access problems in Option I[SM]. Option I[SM] enrollees were more likely than others to report access problems for home health and durable medical equipment, both of which had high rates of co-insurance. [20] However, there were no differences between Option I[SM]

[20] In the 2004 version of Option I[SM], Sterling reduced rates of co-insurance for home health (from 35 percent to 25 percent) and DME (from 50 percent to 40 percent).

enrollees and other Medicare beneficiaries in reported access to hospital, physician and other services. In all plan arrangements, disabled beneficiaries were more likely than aged beneficiaries to report access problems. Disenrollees from Option I[SM] were less likely than other M+C enrollees to cite access problems as reasons for leaving.

Option I[SM] enrollees expressed somewhat greater satisfaction with their plan than other M+C and Original Medicare beneficiaries. Both M+C and Original Medicare beneficiaries seemed somewhat less satisfied overall and with complaint procedures than Option I[SM] enrollees. Option I[SM] disenrollees were less satisfied than current Option I[SM] enrollees. Disabled Option I[SM] enrollees lodged complaints more often than their aged counterparts, but were typically more satisfied with how their complaints were handled and with their insurance overall.

There was inconsistent evidence on selection bias, based on self-reports. In general, there was no evidence that Option I[SM] enrollees or disenrollees were more or less healthy or functionally challenged than Medicare beneficiaries in Original Medicare and other M+C plans. Although disabled Option I[SM] enrollees were more likely to report functional impairments, they reported fewer chronic conditions and viewed their health current and future health status more positively than other disabled beneficiaries.

4.1.2 Humana Gold Choice[SM]

Enrollment growth has been steady and rapid. In its brief history, Gold Choice[SM] has grown steadily, from zero in February 2003 to 11,590 by September 2004.

Gold Choice[SM] enrollment has been geographically concentrated and market penetration has been low throughout the service area. During the study period, over three-quarters of Gold Choice[SM] enrollees lived in Wisconsin and Iowa. Across the Gold Choice[SM] service area, market penetration remained well below one percent.

Beneficiaries, providers and other stakeholders demonstrated a lack of knowledge of Gold Choice[SM]. Even in Wisconsin and Iowa, markets with the highest Gold Choice[SM] penetration, half of the stakeholders contacted for this evaluation had no knowledge of the program.

Gold Choice[SM] enrolled a relatively young and rural enrollee population. Most early enrollees came from Original Medicare. Compared to the average beneficiary in Original Medicare or other M+C plans in the Gold Choice[SM] service area, Gold Choice[SM] enrollees tended to be white, young, more likely to be disabled, previously in Original Medicare, and living in rural counties.

Gold Choice[SM] experienced a relatively modest rate of disenrollment. Over the first year and a half, the Gold Choice[SM] disenrollment rate was no different from the average for other M+C plans. Compared to current enrollees, disenrollees tended to be older, more likely to be disabled, and more likely to live in rural counties or in counties adjacent to urban areas than current enrollees.

A low-cost premium attracted enrollees to Gold Choice[SM]. Cost was by far the most important reason why focus group participants purchased Gold Choice[SM].

There was no evidence of access or satisfaction problems. Few focus group participants had experienced any difficulty getting their doctors to accept Gold Choice[SM]. Most planned to continue in the program, and many had recommended Gold Choice[SM] to others.

4.2 Conclusion: PFFS After the Medicare Modernization Act

Seven years after passage of the Balanced Budget Act of 1997, and four years after Sterling Life Insurance introduced Option I[SM], PFFS' accomplishments have been modest. Although both Sterling and Humana conformed to Congress' wish to increase M+C access in rural areas, PFFS remains a small program, unavailable in many parts of the country, with limited market presence in those areas where it is available.

Recently, several factors suggest that PFFS' prospects may have improved. Humana Gold Choice[SM] enrollment has grown steadily since 2003, and Humana began marketing Gold Choice[SM] in an expanded geographic service area in August 2004. Sterling Option I[SM] has apparently reversed a downward trend in enrollment and shows some signs of growth. In the last year, two new PFFS products have entered the market. Additionally, PFFS plans share the benefits conferred on Medicare Advantage plans by the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) in the form of higher payment rates. Growth is also suggested by the addition of new plans. Three new plans, Unicare, United Healthcare Insurance and American Progressive Life and Health Insurance of New York, joined the PFFS program in 2004. Several applications are currently in the review process.

The future success of PFFS depends on several factors, including strategic and tactical decisions by current PFFS plans and new entrants, as well as external market and regulatory forces over which plans have little control.

Sterling entered the PFFS market with a single product sold at a uniform premium throughout its service area. Over time, Sterling made modifications to Option I[SM] by raising premiums, by withdrawing from part of its initial service area and by diversifying the product. This strategy may pay off, as recent increases in Option I[SM] enrollment seem to suggest.

It is too soon to tell how new PFFS entrants will adjust to evolving market conditions. Aside from its Medigap products, Sterling's experience with Medicare before it offered Option I[SM] was rudimentary. Other plans, (like Humana which brought its extensive M+C experience to the process of designing and marketing Gold Choice[SM]) may apply very different benefit designs and marketing approaches for their PFFS products.

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